Index-Contraindications for Childhood Immunization

Contraindications for Childhood Immunization

CONTRAINDICATIONS	VACCINATE?					
Symptom or Condition 9	**Hep B** 9	**DTaP** 9	**HIB** 9	**EIPV** 9	**MMR** 9	**Var** 9
Allergies (Anaphylactic)						
to Baker's yeast	No	Yes	Yes	Yes	Yes	Yes
to duck meat or duck feathers	Yes	Yes	Yes	Yes	Yes	Yes
to eggs-See Note 1	Yes	Yes	Yes	Yes	Yes	Yes
to gelatin	Yes	Yes	Yes	Yes	No	No
to neomycin	Yes	Yes	Yes	No	No	No
to penicillin	Yes	Yes	Yes	Yes	Yes	Yes
to streptomycin	Yes	Yes	Yes	No	Yes	Yes
to thimerosal	No	No	No	Yes	Yes	Yes
nonanaphylactic	Yes	Yes	Yes	Yes	Yes	Yes
in relatives	Yes	Yes	Yes	Yes	Yes	Yes
Anaphylaxis (life-threatening reaction to previous dose of vaccine)					See Note 2	
Antimicrobial Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Breast feeding	Yes	Yes	Yes	Yes	Yes	Yes
Convalescing From Illness	Yes	Yes	Yes	Yes	Yes	Yes
Convulsions (fits, seizures)						
family history-See Note 3 (including epilepsy)	Yes	Yes	Yes	Yes	Yes	Yes
within 3 days of previous dose of DTaP	Yes	See Note 4	Yes	Yes	Yes	Yes
Diarrhea						
mild	Yes	Yes	Yes	Yes	Yes	Yes
moderate to severe	No	No	No	No	No	No
Exposure to Infectious Disease	Yes	Yes	Yes	Yes	Yes	Yes
Fever						
low-grade fever, with or without mild illness	Yes	Yes	Yes	Yes	Yes	Yes
fever with moderate to severe illness					See Note 5	
HIV Infection						
in household contact	Yes	Yes	Yes	Yes	Yes	Yes
in recipient (asymptomatic)	Yes	Yes	Yes	Yes	Yes	No
in recipient (symptomatic)	Yes	Yes	Yes	Yes	Note 6	No
IG administration (IM or IV)	Yes	Yes	Yes	Yes	Note 7	Note 8
Illness						
mild (with or without fever)	Yes	Yes	Yes	Yes	Yes	Yes
moderate to severe (with or without fever)	No	No	No	No	No	No
chronic					See Note 9	

Contraindications (cont.)

CONTRAINDICATIONS	VACCINATE?					
Symptom or Condition 9	**Hep B** 9	**DTaP** 9	**HIB** 9	**EIPV** 9	**MMR** 9	**Var** 9
Immunodeficiency (other than HIV)						
family history	Yes	Yes	Yes	Yes	Yes	Note 10
in household contact	Yes	Yes	Yes	Yes	Yes	Yes
in recipient-See Note 11	Yes	Yes	Yes	Yes	No	No
Neurologic Disorders, underlying	Yes	Note 12	Yes	Yes	Yes	Yes
Otitis Media						
mild (with or without fever)	Yes	Yes	Yes	Yes	Yes	Yes
moderate to severe	No	No	No	No	No	No
resolving	Yes	Yes	Yes	Yes	Yes	Yes
Pregnancy (mother or household contact)	Yes	Yes	Yes	Yes	Yes	Yes
Prematurity					See Notes 13 and 14	
Reactions to Previous Dose of Any Vaccine						
anaphylactic(life-threatening)-Note15	No	No	No	No	No	No
local(redness/swelling)	Yes	Yes	Yes	Yes	Yes	Yes
Reations to Previous Dose of DTP/DTaP						
collapse or shock-like state within 48 hours	NA	Note 16	NA	NA	NA	NA
persistent, inconsolable crying lasting for ≥3 hours within 48 hours	NA	Note 16	NA	NA	NA	NA
encephalopathy within 7 days	NA	No	NA	NA	NA	NA
family history of adverse event	NA	Note 17	NA	NA	NA	NA
fever of <105 F within 48 hours	NA	Note 17	NA	NA	NA	NA
fever of ≥105 F within 48 hours	NA	Note 16 & 17	NA	NA	NA	NA
Guillain-Barre syndrome (GBS) within 6 weeks after a dose	NA	Note 18	NA	NA	NA	NA
seizures within 3 days after a dose	NA	Note 16 & 17	NA	NA	NA	NA
Simultaneous Administration-Note 19	Yes	Yes	Yes	Yes	Yes	Yes
Hx-Sudden Infant Death Syndrome	Yes	Yes	Yes	Yes	Yes	Yes
Thrombocytopenia	Yes	Yes	Yes	Yes	Note 20	Yes
Thromboctyopenia Purpura (history)	Yes	Yes	Yes	Yes	Note 20	Yes
TB Skin Testing (simultaneously)	Yes	Yes	Yes	Yes	Note 21	Yes
Unvaccinated Household Contact	Yes	Yes	Yes	Note 22	Yes	Yes
Vomiting						
mild (with or without fever	Yes	Yes	Yes	Yes	Yes	Yes
moderate to severe (with or without fever)	No	No	No	No	No	No

Notes to Contraindications for Childhood Immunization

Note 1: Children who are allergic to eggs may be vaccinated. Studies have documented the safety of measles and mumps vaccine (which are grown in chick embryo tissue culture) in children with severe egg allergy. ACIP recommends routine vaccination of egg-allergic children without the use of special protocols or desensitization procedures. Egg allergies remain a contraindication to influenza vaccination.

Note 2: Contraindicates vaccination only with vaccine to which reaction occurred. (Also see “Allergies”.)

Note 3: Consider giving acetaminophen before DTaP and every 4 hours thereafter for 24 hours to children who have a personal or family history of convulsions. (If an underlying neurologic disorder is involved, also see “Neurologic disorders”.)

Note 4: Not a contraindication, but a precaution. Consider carefully the benefits and risks of this vaccine under these circumstances. If the risks are believed to outweigh the benefits, withhold the vaccination; if the benefits are believed to outweigh the risks (for example, during an outbreak), give the vaccine. (If convulsions are accompanied by encephalopathy, also see “Reactions to a previous dose of DTaP.” If an underlying neurologic disorder is involved, also see “Neurologic disorders”.)

Note 5: Children with moderate or severe febrile illness can be vaccinated as soon as they are recovering and no longer acutely ill.

Note 6: MMR should be considered for all symptomatic HIV-infected children, including children with AIDS, since measles disease in these children can be severe. Limited data on MMR vaccination among both asymptomatic and symptomatic HIV-infected children indicate that MMR has not been associated with severe or unusual adverse events, although antibody responses have been unpredictable.

Note 7: Do not give immune globulin products and MMR simultaneously. If unavoidable, give at different sites and revaccinate or test for seroconversion in 3 months. If MMR is given first, do not give IG for 2 weeks. If IG is given first, the interval between IG and measles vaccination depends on the product, the dose and the indication.

Note 8: Do not give varicella vaccine for at least 5 months after administration of blood (except washed red blood cells) or after plasma transfusions, IG, or VZIG. Do not give IG or VZIG for 3 weeks after vaccination unless the benefits exceed those of vaccination. In such instances, either revaccinated 5 months later or test for immunity 6 months later and revaccinate if seronegative.

Note 9: The great majority of children with chronic illnesses should be appropriately vaccinated. The decision whether or not to vaccinate these children, and what vaccines to give, should be made on an individual basis.

Note 10: Do not give varicella vaccine to a member of household with a family history of immunodeficiency until the immune status of the recipient and other children in the family is documented.

Note 11: A protocol exists for use of varicella vaccine in patients with acute lymphoblastic leukemia (ALL). See Varicella Prevention: Recommendation of the Advisory Committee on Immunization Practices.

Note 12: Whether and when to administer DTaP to children with proven or suspected underlying neurologic disorders should be decided individually. Generally, infants and children with stable neurologic conditions, including well-controlled seizures, may be vaccinated.

Note 13: The appropriate age for initiating vaccinations in the prematurely born infant is the usual chronologic age (same dosage and indications as for normal, full term infants).

Note 14: For hepatitis B vaccine, if the mother is antigen-positive, use the vaccine schedule in which the first dose is given at birth.

Note 15: Not a contraindication, but consider carefully the benefits and risks of this vaccine under these circumstances. If the risks are believed to outweigh the benefits, withhold the vaccination; if the benefits are believed to outweigh the risks (for example, during an outbreak or foreign travel), give the vaccine.

Note 16: Consider giving acetaminophen before DTaP and every 4 hours thereafter for 24 hours to children

who have a personal or a family history of convulsions.

Note 17: The decision to give additional doses of DTaP should be based on consideration of the benefit of further vaccination versus the risks of recurrence of GBS. For example, completion of the primary series in children is justified.

Note 18: There is a theoretical risk that the administration of multiple live virus vaccines (MMR and varicella) within 30 days of one another if not given on the same day will result in a suboptimal immune response. There are no data to substantiate this with current vaccines.

Note 19: Consider the benefits of immunity to measles, mumps and rubella versus the risks of recurrence of exacerbation of thrombocytopenia after vaccination or risks from natural infection of measles or rubella. In most instances, the benefits of vaccination will be much greater than the potential risks and justify giving MMR, particularly in view of the even greater risk of thrombocytopenia following measles or rubella disease. However, if a prior episode of thrombocytopenia occurred near the time of vaccination, it might be prudent to avoid a subsequent dose.

Note 20: Measles vaccination may temporarily suppress tuberculin reactivity. MMR vaccine may be given after, or on the same day as TB testing. If MMR has been given recently, postpone the TB test until 4-6 weeks after administration of MMR. If giving MMR simultaneously with tuberculin skin test, use the Mantoux test, not multiple puncture tests, because the latter, if results are positive, require confirmation (and confirmation would then have to be postponed 4-6 weeks).

Kansas Immunization Program
Bureau of Epidemiology and Disease Prevention
Kansas Department of Health and Environment

9/01